Denti-Cal

California Medi-Cal Dental Program

Electronic Data Interchange

edi

Denti-Cal

EDI Companion

Guide

EDI

Denti-Cal EDI Companion Guide

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1. INTRODUCTION

Electronic Data Interchange or EDI is a quick, efficient method of transmitting data to Denti-Cal via your computer. Eliminating hardcopy submission of data can save money on your practice resources and reduce the rate of document errors. That's why participating EDI providers experience improved cash flow, a marked decrease in paperwork, and more efficient use of office staff.

1.1 Overview of EDI

Denti-Cal's EDI service is an optional method of data submission available to all participating Denti-Cal providers. EDI is an easy, efficient, paperless system that uses telephone lines to transmit information from your office's computer to Denti-Cal, and transmit information back from Denti-Cal to your computer.

Providers using EDI may electronically transmit the following document types:

- Claim
- Treatment Authorization Request (TAR)
- Notice of Authorization (NOA)
- Resubmission Turnaround Document (RTD)
- Claim Inquiry Form (CIF), which includes:
  - Claim Adjustment
  - Claim Status Request

EDI trading partners (submitters) may elect to send all of the above documents electronically, or to send only claims and TARs. If submitters elect to send only claims and TARs, this choice does not preclude sending the other document types at a later date.

Optionally, submitters may elect to receive information electronically. The type of information that can be received includes NOA, RTD and Explanation of Benefits (EOB) data. With proper support in the Practice Management System, EOB data can allow submitters to post claim payment information electronically to their accounts.

To participate in EDI the following are required:

- Select a computer system and appropriate software.
- Contact Denti-Cal for an EDI Enrollment form.
- Complete Testing and Certification successfully.

COMPANION GUIDE OVERVIEW

Section 1 – Introduction

Provides an overview of EDI features and requirements for EDI participation.

Section 2 – Communications

Identifies communications parameters.

Section 3 – Reports and Data Files

Specifies data formatting requirements.

Section 4 – Transaction Set 837 Electronic Claims Submission

Shows the Testing Plan & Record Layout for this transaction set, and features a Denti-Cal Paper Claim to 837 Cross Reference.

Section 5 – Transaction Sets 276/277 Request & Response Functions

Illustrates the Testing Plan and Record Layout for the request and response transaction sets.

Section 6 – Testing and Certification Process

Defines testing and certification requirements for EDI participation.

Appendix A – EOB Data File

Presents and defines EOB Data File record format and fields.

Appendix B – Report Examples

Contains EDI report examples and descriptions.

1.2 Costs

There is no charge from Denti-Cal to use EDI. Your practice management system vendor and billing intermediary or clearinghouse, if you use one, do charge for their services, and these costs may vary. You will likely save money using EDI, as studies have shown that sending data electronically reduces paperwork and improves the efficiency of your office, resulting in decreased administrative costs.

1.3 Technical Assistance

Your practice management system vendor will provide technical assistance with your computer hardware or software. Denti-Cal's EDI Support staff can assist you or your vendor with questions regarding technical requirements. Also, during the testing phase, EDI Support works with you or your vendor to resolve any problems identified during the testing and certification process. Once the testing phase is successfully completed, EDI Support's help desk provides continued assistance to your office personnel or vendor representative. They will answer questions regarding problems you may be experiencing with your EDI data transmissions.

1.4 Getting Started

To participate in EDI, you will need a computer and modem (hardware), and a computer program (software) that will allow you to transmit data electronically to Denti-Cal. If you already use a computer system to maintain your electronic billing information, you may need your system upgraded to submit data electronically. A practice management (or office management) system vendor can help you upgrade your system, or select a computer system and software that best meet the needs of your office for processing Denti-Cal data electronically. When you have selected a computer system and appropriate software, contact Denti-Cal for an EDI Enrollment form. Once enrollment processing, and testing and certification are successfully completed, you can begin submitting data electronically.

1.5 EDI Enrollment

To enroll in Denti-Cal EDI, providers, billing intermediaries and clearinghouses must submit a completed EDI application. The following enrollment forms can be requested from and must be returned to Denti-Cal EDI Support:

- EDI Provider Application / Agreement Form (Providers must complete.)
- *EDI Clearing House and Billing Intermediary Application / Agreement Form* (Clearinghouses or billing intermediaries must complete for providers who have chosen to associate with a billing service for the submission of their electronic documents.)

1.6 Documents Accepted Through EDI

Trading partners may initially elect to transmit claims and TARs only. If, at a later date, a trading partner decides to submit other document types through EDI, additional testing will be required before these documents may be transmitted for processing.

Corrections in response to an RTD may be submitted either electronically or on hard copy. Hard copy corrections may be submitted on the standard Denti-Cal RTD form, or by returning report CP-O-RTD-P with the appropriate information added. If the CP-O-RTD-P report is returned in response to an RTD, then the submitter first must elect to receive Denti-Cal reports electronically. When submitted electronically, the RTD totally replaces the original document; therefore, it must contain everything required of that document type (claim or TAR) along with the corrected information. Like the RTD, a NOA may also be submitted on either hard or electronic copy.

The NOA report (CP-O-NOA-P) may be used for billing in place of the current NOA form. See Appendix B for examples of the CP-O-RTD-P and CP-O-NOA-P reports.

Note that if a TAR was originally submitted on paper, the corresponding NOA may not be submitted electronically.

All documents submitted must conform to the appropriate version of the ASC X12 Implementation Guide. This submission format can be obtained from the Washington Publishing Company web site. The specific X12 segments and data elements required for Denti-Cal are documented in Sections 4 and 5 of this Companion Guide.

1.7 Document Control Numbers (DCNs)

All documents sent electronically or hardcopy, are tracked by Denti-Cal using a unique identifier called a Document Control Number (DCN). The DCN is assigned the day the document is electronically stored in the Denti-Cal system. The DCN is returned electronically on EDI reports.

Denti-Cal trading partners also assign a unique identifier to each EDI document, but not to hardcopy documents. The unique identifier assigned by trading partners is referred to as a Provider Document Control Number or PDCN. Returning EDI documents, such as NOAs, RTDs, and claim adjustments, must contain the originally assigned Denti-Cal DCN and the original Denti-Cal PDCN.

In the case of EDI adjustments, for which the original claim was hardcopy, there is no original PDCN to submit because the PDCN is not supported for hardcopy documents. In these cases, a new PDCN must be sent with each EDI adjustment, along with the original Denti-Cal DCN.

1.8 Acknowledgment of Receipt

On an ongoing basis, Denti-Cal receives electronic transactions from each submitter's "mailbox". These transactions are stored on the Denti-Cal mainframe and processed daily, Monday through Friday. A report, CP-O-973-P (Provider/Service Office Daily EDI Documents Received Today) is generated for electronic claims, TARs, NOAs, RTDs and Claim Adjustments, and sent to submitters who have elected to receive Denti-Cal reports electronically. The '973' report contains detailed information about each document received. An example of this report can be found in Appendix B.

For the X12 276 transaction (Health Care Claim Status Request), no Denti-Cal report is returned. Instead, the X12 277 transaction (Health Care Claim Status Response) is sent in response to the 276.

The X12 transaction, called Functional Acknowledgment (997), is used as the first response to receiving an 837. Note that this transaction is NOT supported by Denti-Cal.

1.9 Technical Overview

Denti-Cal provides for the electronic submission of claims, TARs, NOAs, RTDs, Claim Adjustments and Claims Status Requests. Electronic adjustments are equivalent to using the Claim Inquiry Form (CIF) with the box "Claim Re-evaluation Only" checked. Providers, independently or through clearinghouses or billing intermediaries, may transmit documents electronically to Denti-Cal, and optionally receive electronic transmissions in return.

To participate in EDI, a provider, clearinghouse or billing intermediary must demonstrate the ability to transmit documents in the dental version of the ASC X12 837 format. This format is documented in the National Electronic Data Interchange Transaction Set Implementation Guide – Health Care Claim: Dental.

Testing

Denti-Cal trading partners must successfully complete a testing and certification process prior to participation in EDI. The testing and certification process verifies the trading partner's ability to:

- Establish communications with the EDI system
- Create and transmit documents in the proper format
- Receive reports
- Return corrected and/or missing information when necessary

Section 6, Testing and Certification Process, further describes these requirements. Additional details regarding the process, specifically for the 837 and 276/277 transactions are presented in Sections 4.2 and 5.2, respectively.

Communications

Denti-Cal supports asynchronous communication, also referred to as dial-up. Trading partners must have a computer with modem and appropriate communications software, such as Procomm, to establish EDI sessions with Denti-Cal.

Data transmission activity is supported 24 hours daily, Monday through Saturday; and from 12 noon through 12 midnight on Sunday. Documents received by 3:45 P.M. Monday through Friday, holidays excluded, are entered into that evening's processing.

See Section 2, Communications, for detailed communications parameters and other requirements for interfacing with the Denti-Cal EDI system.

Remote ID and Password Assignment

A remote ID and password are required for any data communication with the Denti-Cal EDI system. The remote ID and password values are used when dialing in to Denti-Cal using ProComm or similar communications software. As part of the testing and certification process, trading partners are assigned a temporary remote ID and password. The temporary remote ID and password are used for testing purposes only. Once the testing and certification process is successfully completed, trading partners are given a permanent remote ID and password.

1.10 X-rays and Hardcopy Attachments for EDI Documents

Documents may be transmitted electronically even though they require X-rays and/or hardcopy attachments. Using this feature of the EDI facility requires coordination in two areas:

- For EDI documents, the x-ray and attachment indicators illustrate that X-rays and/or hard copy attachments are being mailed.
- Document Control Numbers (DCNs) must be included with these EDI documents using the DCN that matches the number manually entered by the provider on the x-ray envelope or attachment header sheet. The DCN may be the practice management system's internal DCN or the DCN that Denti-Cal supplies on its electronic reports.
- You are required to mail hardcopy documentation, such as X-rays, periodontal charting, or other kinds of attachments when necessary to process your documents. Denti-Cal supplies EDI labels for affixing to supporting documentation and specially marked envelopes for mailing required x-rays.

Comments

The EDI health care claim format allows for the electronic submission of "comments" pertinent to the services performed. This feature is available for each service line or for the entire document.

1.11 Reports and Data Files

Providers may choose to receive a number of reports electronically. In some cases, these reports replace hardcopy forms currently received by the provider. Reports are listed in Section 3.2, Reports Available, and Appendix B – Report Examples.

EOB Data

Providers may choose to receive EOB information in data format. This option is made available for providers planning to perform automated reconciliation of receivables within their practice management systems.

See Section 3.5, Explanation of Benefits Data, and Appendix A – EOB Data File, for further information.

– End of Section –

2. COMMUNICATIONS

2.1 Overview

Denti-Cal's EDI facility features dial-up communications using the ZMODEM protocol. Communications are available 24 hours a day, Monday through Saturday, from 12 noon through 12 midnight on Sunday. More than one transmission type may be scheduled during a single communications session. The following sections discuss the communications requirements for connecting and disconnecting to Denti-Cal EDI, transmitting files, and receiving reports and other data.

COMMUNICATIONS OVERVIEW

- Communications options
- Communications parameters
- Modem compatibility
- Communications control commands.

2.2 Asynchronous Communications

Denti-Cal supports asynchronous data communications using ZMODEM. ZMODEM is the preferred protocol because of its speed and error correction capabilities. ZMODEM is Hayes compatible and runs on any version of ProComm software.

The table below illustrates how asynchronous communications parameters may be set.

2.2-1, Asynchronous Communications Parameters

Number of Bits per Character	8
Parity	None
Number of Stop Bits	1
Baud Rate	Up to 28,800 (Transmission speed will vary depending on protocol, equipment being used and phone line conditions.)
Record Separator	X'0D0A' (Carriage Return/Line Feed)

A maximum record size of 4096 bytes may be transmitted.

2.3 ZMODEM Features

The ZMODEM protocol requires entering a logon ID and password prior to sending or receiving data. When retrieving data, the filename stored on the receiver's system is controlled by the sender and cannot be overridden by the receiver.

Denti-Cal generates the following filename: **deltmmddttttt**

- delt = a constant
- mmdd = current month and day
- ttttt = current time in elapsed seconds since midnight on the current day

ZMODEM protocol includes Crash Recovery options. It is important to understand what the options are when the generated file name is identical to the name of a file on the receiver's system. Following are the two options that can be set on the receiver's system.

1. Overlay the existing file with the new file being downloaded.

2. Rename the file being downloaded.

The second or rename option is highly recommended to avoid overlaying or replacing existing data. Under the rename option, if an identical filename is found, ZMODEM continues to increment the last three characters of the filename until a completely new filename is designated (i.e., one that does not match any filename already on the receiver's system).

2.4 File Transfers Using ZMODEM

For the most current dial-up number, contact Denti-Cal's EDI Support.

- Enter your remote ID (Alpha characters must be entered in UPPER CASE.)
- Enter your password (Alpha characters must be entered in UPPER CASE.)

Once you have successfully logged on, a prompt appears, after which you may enter commands to send or retrieve data. The $$ADD command is for sending data, while $$REQ is for data retrieval.

The UPLOAD command may also be used to send data. To send claims, either type UPLOAD or enter the command $$ADD BID='DC-CLAIMS'. If you use UPLOAD, the $$ADD command(s) must be embedded in the file to be sent. If the $$ADD command is used, there should be no $$ADD commands imbedded in the file.

If the $$ADD command is entered at the prompt and a $$ADD command is imbedded in the data, the transmission will appear to have worked properly, but the claims may be rejected.

See Exhibit 2.4-1 for additional ZMODEM commands.

2.4-1, Common ZMODEM Commands

Command	***Description***
$$DIR	Displays all files. Useful for determining if any files are available for downloading.
$$REQ	Downloads all files available, which includes reports, labels and EOB data.
$$REQ BID='DC-REPORTS'	Downloads all available report files.
$$REQ BID='DC-REPORTS' ONEBATCH=Y	Downloads a single report file. The term ONEBATCH can be abbreviated to OB.
$$REQ BID=#nn	Downloads a specific batch number. Batch numbers can be obtained by entering the $$DIR command. Replace nn with the batch number to be downloaded.
UPLOAD	Uploads claims when the file being uploaded contains $$ADD commands.
$$ADD BID='DC-CLAIMS'	Uploads claims when the file being uploaded does not contain $$ADD commands.
BYE	Ends dial-up session.

2.5 Report Retrieval

Submitters have the option of receiving a number of EDI reports and data. Information may be requested following transmission of data files or in a standalone session. Reports, EOBs and labels must be requested separately. Format for the data collection request is illustrated below.

2.5-1, Data Collection Request

$$REQ BATCHID='DC-REPORTS' To receive reports

$$REQ BATCHID='DC-EOBS' To receive EOBs

$$REQ BATCHID='DC-LABELS' To receive labels

(BATCHID can be abbreviated as BID)

The file download begins shortly after the $$REQ statement is entered. The sender will receive all files that have not been previously transmitted to this remote.

– End of Section –

3. REPORTS AND DATA FILES

3.1 Overview

A number of reports are available for electronic receipt at the option of the provider. Also, Explanation of Benefits information may be selected for receipt in either a report or data format. Reports are "mailboxed" into individual files and enveloped using the X12 enveloping structure. Form-feed characters, X'0C' are imbedded into the reports to denote the start of each new page of the report. Report information is returned in upper case with blank lines embedded as necessary, and a maximum of 59 lines per page.

This Companion Guide should be used in conjunction with the most recent version of the X12 837 Dental Implementation Guide, which is published by the Washington Publishing Company (WPC).

Reports may be printed by sending them directly to the printer. See Appendix B – Report Examples, for more detail. Labels and EOB data may be retrieved separately from other returned information as described below.

REPORTS AND DATA FILES OVERVIEW

Details the availability of reports and EOB data which, at the provider's option, may be received electronically. Provides a short summary of report content.

Describes the ASC X12 transmission enveloping requirements. Every file transmitted to Denti-Cal is enveloped with data that identifies the sender, receiver and transmitted file.

Illustrates control segments and delimiters for sending X12 data files to Denti-Cal.

Discusses use of EDI labels for documents, x-rays and attachments.

The following sections identify the X12 enveloping structure as it pertains to reports and data, and describe the EDI reports available.

3.2 Reports Available

In some cases, EDI reports replace existing hardcopy reports that the provider currently receives; in other cases, they offer new information. Below are brief descriptions of the reports available. (See Appendix B for sample report formats.)

Notice of Authorization (CP-O-NOA-P)

Providers may opt to receive the electronic NOA in lieu of the hardcopy form. It presents Denti-Cal's authorization of services requested by the provider on a Treatment Authorization Request (TAR). If a provider selects this option, the electronic NOA may be printed, completed, signed and returned to Denti-Cal for billing.

Notice of Resubmission (CP-O-RTD-P)

The electronic Resubmission Turnaround Document (RTD) is also available to providers participating in EDI, and if selected, replaces the hardcopy RTD documents. It identifies requests for missing or additional information, and may be printed, completed, signed and returned to Denti-Cal for processing.

Provider/Service Office Document Rejections (CP-O-959-P)

This report lists EDI transactions that Denti-Cal has rejected. These documents must be corrected and retransmitted before they can be processed.

Provider X-ray/Attachment Request (CP-O-971-P)

This report identifies TARs and claims that require X-rays and/or hard copy attachments for processing. By providing both Denti-Cal's assigned DCN and the provider's PDCN, the report enables providers to identify the TARs and claims requiring X-rays and/or hard copy attachments.

Provider X-ray/Attachment Labels (CP-O-971-P2)

Labels are produced for submitters to use in identifying the claims, TARs and RTDs associated with the X-rays and attachments sent to Denti-Cal through the mail. The data in these labels has been preformatted to match special labels designed for the EDI process. Providers receiving these labels must affix them to x-ray envelopes or Attachment Header Sheets before mailing.

Provider/Service Office Daily EDI Documents Received Today (CP-O-973-P)

This report lists all EDI documents received on the report date prior to the daily cutoff time.

Provider Daily Report of EDI Documents Waiting Return Information > 7 Days (CP-O-978-P)

This report lists all EDI documents that have been awaiting X-rays and/or hardcopy attachments for more than seven days.

3.3 Report and Data Enveloping

Reports and EOB data are "mail boxed" using the standard X12 enveloping structure. This enveloping structure and its relation to the returned information is displayed below. The GS/GE envelope is repeated for each provider or service office.

3.3-1, GS/GE Enveloping

Loop	Segment	Data Elements
ENV	ISA	*00*DENTICAL *00*NONE *ZZ*DENTICAL *ZZ*remote-id *YYMMDD *HHMM*00303*trans control nbr*0*P/T*"$^{N}_{L}$
GS	GS	*TX*DENTICAL*final destination provider ID and office number-*YYMMDD*HHMM*X*003030$^{N}_{L}$
GS	ST	*864*DENTICAL$^{N}_{L}$
GS	BMG	*ZZ*REPORTS FOR provider name$^{N}_{L}$
MIT	MIT	*RPT$^{N}_{L}$
MIT		80 character report lines$^{N}_{L}$
GS	SE	*count of segments from ST thru SE*DENTICAL$^{N}_{L}$
GS	GE	*number of ST/SE sets*DENTICAL$^{N}_{L}$
ENV	IEA	*Number of GS/GE sets*trans control number$^{N}_{L}$

3.4 Control Segments and Delimiters

The X12 standard requires the use of Control Segments and a transaction set header and trailer. The standard also requires delimiters for data elements, component data elements, and segments. The Interchange Control Header (ISA Segment) sets the value of each of these delimiters.

Exhbit 3.4-1 below shows the recommended delimiter values for sending X12 data files to Denti-Cal.

3.4-1, Delimiters for X12 Data Files

Data Element Separator	Hexadecimal '1D', decimal 29
Component Element Separator	Hexadecimal '7F', decimal 127
Segment Terminator	Hexadecimal '1C', decimal 28

Another Denti-Cal requirement is the carriage return, line feed sequence (CRLF) at the end of each segment. On the PC platform, the value of CRLF is hexadecimal '0D0A'. CRLF should always follow the segment terminator. Depending on how the data file is created, it may or may not be necessary to manually add the CRLF at the end of each segment. Most off-the-shelf PC applications automatically create this sequence when generating ASCII files.

Exhibit 3.4-2 illustrates the control segments, including the transaction set header and trailer. The asterisk (*) represents the data element separator, and the pound sign (#) represents the segment terminator. The characters 'REMOTEID' should be replaced with the unique Remote ID assigned to each Denti-Cal trading partner.

3.4-2, Sample Control Segments

```
ISA*00*DENTICAL  *00*NONE     *ZZ*REMOTEID      *ZZ*DENTICAL      *040213*1432*U*00401*111114993*1*P*"#
GS*HC*REMOTEID*DENTICAL*20040213*1432*111114993*X*004010X097A1#
ST*837*111114993#

SE*5712*111114993#
GE*1*111114993#
IEA*1*111114993#
```

3.5 Explanation of Benefits Data

Explanation of Benefits information may be received in data format in addition to hardcopy format. The data is enveloped using the standard X12 envelope structure noted above. Data is presented in upper case format.

Data available in the EOB Data File includes adjudicated claims, accounts receivable and payable transactions, levy information and check cycle summary information. Refer to Appendix A – EOB Data File, for details on EOB Data File record layouts and field definitions.

3.6 Labels

Labels are produced for submitters to use in identifying the claims, TARs, Adjustments and NOAs associated with x-rays and attachments sent to Denti-Cal through the mail. Providers receiving the labels, affix them to x-ray envelopes or Attachment Header Sheets before mailing. The information returned as part of the Provider X-ray/Attachment Labels report (CP-O-971-P2) file is formatted to fit EDI-designed labels.

4. TRANSACTION SET 837 – CLAIMS SUBMISSION

4.1 Overview

TRANSACTION SET 837 OVERVIEW

Explains Trading Partner Certification Procedures

Illustrates Record Layout

This section presents an overview of the ASC X12 transaction set 837 Health Care Claim format as required by Denti-Cal. The ASC X12 837 is composed of:

- Areas (such as billing provider information),
- Segments (records of data about the area) within areas, and
- Data fields within segments.

Each data field represents one fact about the subject of the segment such as the patient's Medi-Cal ID.

Personnel responsible for implementing the computer software that formats the electronic documents can use this section as a guide to the ASC X12 837 health care claim structure.

4.2 Trading Partner Certification Procedures

Denti-Cal trading partners must be certified for the ASC X12 837 transaction prior to sending production data. Certification is required for each type of 837 transaction the trading partner intends to send. This includes the following types of documents:

- Claims
- Treatment Authorization Requests (TARs)
- Resubmission Turnaround Documents (RTDs)
- Notices of Authorization (NOAs)
- Claim Adjustments

The trading partner is assigned a test Remote ID (also know as a Mailbox), a password, and a phone number for dialing in to perform the data transmission. The Remote ID and the password are needed for logging on to the Denti-Cal EDI system. When submitters have test 837 transactions ready to send, they will dial in using the supplied phone number and appropriate software (ProComm is the software of choice) and log on using the supplied Remote ID and password. The trading partner then issues appropriate commands to send test EDI data to Denti-Cal where it will be placed in the designated Mailbox.

As part of the testing process, Denti-Cal EDI Support will place sample reports and labels into the same Mailbox the trading partner is using for testing. To retrieve these reports and labels, the trading partner can dial in separately, or can retrieve the reports and labels during the same dial-up session that was established for transmitting the 837 transactions. Appropriate commands will be issued for retrieving these reports and labels. The reports and labels contain sample data only, and that data is not related in any way to the data the trading partner sends in the 837 transactions.

The certification process generally requires multiple iterations of the following process:

- The trading partner sends test 837 transactions.
- Denti-Cal EDI Support critiques the 837 transactions, responding to the trading partner with any problems found with the transactions.
- The trading partner makes appropriate changes to the 837 transactions, correcting any problems, and sends the corrected 837 transactions to Denti-Cal.

When the test 837 transactions are error free, the trading partner can begin sending production data. The first time the trading partner sends production data, it will be a limited number of transactions, mutually agreed upon by the trading partner and Denti-Cal EDI Support. These transactions are closely monitored to ensure they are processed through the Denti-Cal system successfully. If the production transactions have problems, it may be necessary to revisit the certification process and have the trading partner send more test 837 transactions. After a few days of sending a limited number of 837 transactions, the trading partner will be certified to submit production 837 documents electronically to Denti-Cal. An acceptance letter from Denti-Cal EDI Support will serve as an official notice of participation in the EDI program.

4.3 Denti-Cal Requirements for 837 Transaction

Subscriber Identifier

For the 837 transaction, the subscriber identifier can be sent in Loop 2010BA in one of two ways:

1. The NM1 segment – data element NM109
2. The REF*SY segment – data element REF02

Unless there are two different identifiers for the subscriber, only one of these should be sent.

The preferred method of submission is in the REF*SY segment, which can accommodate an identifier up to 9 characters in length. If the subscriber identifier has a length of 10 characters, most likely the last position is a check digit and not part of the identifier; therefore, only the first 9 characters should be sent. If the length of the subscribier identifier exceeds 10 characters in length and is less than 15, then it must be sent in the NM1 segment.

CLM01 Data Element

The CLM01 data element in the CLM segment contains the Provider DCN (PDCN). This is the provider's unique identifer for the submitted document. The *X12 Implementation Guide* indicates that this segment may be up to 20 characters in length. However, since Denti-Cal uses only the first 17 characters, any characters over 17 will be truncated.

Additionally, the PDCN value sent with original documents must be the same value sent on returning documents (NOA/RTD/Adjustment). An adjustment for a document originally sent on hard copy will have no original PDCN associated with it, so a new PDCN must be sent on these documents.

DTP*472 Segment

The DTP*472 segment in the 2300 loop contains the date of service for the entire document. Denti-Cal ignores this segment, instead using the DTP*472 segment in the 2400 loop. Therefore, all dates of service must be sent in the 2400 loop.

4.4 Record Layout for 837 Transaction

The following table shows data elements required by Denti-Cal and where to place those data elements.

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2010AA		**Billing Provider Name**				
2010AA	NM102	Entity Type Qualifier	ID	1/1		2
2010AA	NM103	Name Last or Organization Name	AN	1/35	Billing Provider name	
2010AA	REF01	Reference ID Qualifier	ID	2/2		1D
2010AA	REF02	Reference Identification	AN	6/6	Billing Provider ID	
2010AA	REF01	Reference ID Qualifier	ID	2/2		LU
2010AA	REF02	Reference Identification	AN	2/2	Service Office Number, Value 01 – 99	
2010BA		**Subscriber Name**				
2010BA	NM101	Entity Identifier Code	ID	2/2		IL
2010BA	NM102	Entity Type Qualifier	ID	1/1		1
2010BA	NM103	Name Last or Organization Name	AN	1/35	Subscriber Last Name	
2010BA	NM104	Name First	AN	1/10	Subscriber First Name	
2010BA	NM108	Identification Code Qualifier	ID	2/2		MI

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2010BA	NM109	Identification Code	AN	9/14	Subscriber Medi-Cal ID	
2010BA	N301	Address Information	AN	1/55	Subscriber Address 1	
2010BA	N302	Address Information	AN	1/55	Subscriber Address 2	
2010BA	N401	City Name	AN	2/30	Subscriber City	
2010BA	N402	State Name	ID	5/9	Subscriber State	
2010BA	N403	Postal Code	ID	5/9	Subscriber ZIP Code	
2010BA	DMG01	Date Time Period Format Qualifier	ID	2/2		D8
2010BA	DMG02	Date Time Period	ID	8/8	Subscriber Date of Birth	
2010BA	DMG03	Gender Code	ID	1/1	Subscriber Gender Code	
2010BA	REF01	Reference Identification Qualifier	ID	2/2		SY
2010BA	REF02	Reference Identification	AN	9/9	Subscriber Social Security Number	
2300		**Claim Information**				
2300	CLM01	Claim Submitter's Identifier	AN	1/17	Provider DCN (PDCN)	
2300	CLM02	Monetary Amount	R	1/18	Claim Billed Amount	
2300	CLM05-1	Facility Code Value	AN	2/2	Place of Service Code	

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2300	CLM05-3	Claim Frequency Type Code	ID	1/1	Code indicating original claim or Adjustment	1 or 7
2300	CLM11-1	Related Caused Information	ID	2/2	Accident or Employment Related Indicator	OA or EM
2300	CLM11-2	Related Caused Information	ID	2/2	Accident or Employment Related Indicator	OA or EM
2300	DN201	Tooth Number	AN	1/2	Tooth number of missing tooth	
2300	DN202	Tooth Status Code	ID	1/1	Missing Tooth is only status accepted	M
2300	PWK01	Report Type Code	ID	2/2	X-rays or Attachments indicator	RB or OZ
2300	AMT01	Amount Qualifier Code	ID	2/2		F5
2300	AMT02	Monetary Amount	R	1/18	Subscriber Amount Paid	
2300	REF01	Reference Identifier Qualifier	ID	2/2		F8
2300	REF02	Reference Identification	AN	13/13	Denti-Cal DCN	
2300	NTE01	Note Reference Code	ID	3/3		ADD
2300	NTE02	Description	AN	1-80	Free form comment – up to 20 NTE segments supported	

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2320		**Other Subscriber Information**				
2320	AMT01	Amount Qualifier CD	ID	1/1		D
2320	AMT02	Monetary Amount	R	1/18	Other Coverage Amount	
2400		**Line Counter**				
2400	LX101	Line Counter			Value in this data element must begin with 1 for first line, and increment by 1 for each subsequent line	
2400	SV301-1	Product/Service ID Qualifier	ID	2/2		AD
2400	SV301-2	Product/Service ID	AN	3/5	Dental Procedure Code	
2400	SV302	Monetary Amount	R	1/18	Billed amount for this procedure	
2400	SV303	Facility Code Value	AN	2/2	Code indicating where the service was performed	
2400	SV304-1	Oral Cavity Designation Code	ID	2/2	The following codes are allowed: 01, 02, 10, 20, 30 and 40	
2400	SV306	Quantity	R	1/15	Count of how many of this procedure was performed	
2400	TOO01	Code List Qualifier	ID	2/2		JP
2400	TOO02	Tooth Number	AN	1/2	Tooth Code from National Standard Tooth Numbering System	
2400	TOO03-1	Tooth Surface Code	ID	1/1	Code identifying the surface area of the tooth that was treated	

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2400	TOO03-2	Tooth Surface Code	ID	1/1	Code identifying the 2nd surface area of the tooth that was treated	
2400	TOO03-3	Tooth Surface Code	ID	1/1	Code identifying the 3rd surface area of the tooth that was treated	
2400	TOO03-4	Tooth Surface Code	ID	1/1	Code identifying the 4th surface area of the tooth that was treated	
2400	TOO03-5	Tooth Surface Code	ID	1/1	Code identifying the 5th surface area of the tooth that was treated	
2400	DTP01	Date/Time Qualifier	ID	3/3		472
2400	DTP02	Date Time Period Format Qualifier	ID	2/2		D8
2400	DTP03	Date Time Period	AN	8/8	Date of service	
2400	NTE01	Note Reference Code	ID	3/3		ADD
2400	NTE02	Description	AN	1/80	Free form comment – up to 10 NTE segments supported for each claim line	
2420A	**REF**	**Reference Information**				
2420A	REF01	Reference ID Qualifier	ID	2/2		1D
2420A	REF02	Reference Information	AN	6/6	Rendering Provider ID	

– End of Section –

5. TRANSACTION SET 276/277 – REQUEST AND RESPONSE

5.1 Overview

This section presents an overview of the ASC X12 transaction set 276/277 Health Care Claim format as required by Denti-Cal. The response includes the DCN, a status category code, a status code; and if the claim was processed, a payment date, Denti-Cal check number and payment amount.

TRANSACTION SET 276/277 OVERVIEW

Explains Provider Certification Procedures

Illustrates 276/277 Record Layout

The status codes represent the status of the entire claim, with no claim line status being reported.

5.2 Trading Partner Certification Procedures

Denti-Cal trading partners must be certified for the 276 transactions prior to sending production data.

The trading partner can use the same remote ID (also known as a mailbox ID) and password, and phone number for dialing in as supplied with the 837 certification, to perform the data transmission. When submitters have test 276 transactions ready to send, they will dial in using the supplied phone number and appropriate software (ProComm is the software of choice), and log on using the supplied remote ID and password. Submitters may then issue appropriate commands to send their test EDI data to Denti-Cal, where it will be placed in the designated mailbox.

As part of the testing process, Denti-Cal EDI Support places sample 277 transactions into the same Mailbox the trading partner is using for testing. To retrieve these transactions, the trading partner can dial in separately, or can retrieve the same transactions during the same dial-up session that was established for transmitting the 276 transactions. Appropriate commands are issued for retrieving these transactions. The certification process generally requires multiple iterations of the following process:

- The trading partner sends test 276 transactions.
- Denti-Cal EDI Support critiques the 276 transactions, responding to the trading partner with any problems found with the transactions.
- The trading partner makes appropriate changes to the 276 transactions, correcting any problems, and sends the corrected 276 transactions to Denti-Cal.
- After Denti-Cal processes the 276 transactions, Denti-Cal sends the trading partner the 277 transactions that correspond to the previous 276 transactions.

Eventually, when the test 276 transactions are error free, the trading partner can begin sending production data. The first time the trading partner sends production data, the submission will consist of a limited number of transactions, mutually agreed upon by the trading partner and Denti-Cal EDI Support. These transactions are closely monitored to ensure they are processed through the Denti-Cal system successfully. If the production transactions have problems, it may be necessary to revisit the certification process and have the trading partner send additional test 276 transactions.

After a few days of sending a limited number of 276 transactions successfully, the trading partner will be certified to submit production 276 transactions electronically to Denti-Cal. An acceptance letter from Denti-Cal EDI Support will serve as an official notice of participation in the program.

5.3 Record Layout for 276 Request

Following is the record layout for the ASC X12 276 transaction.

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2100C		**Billing Provider**				
2100C	NM108	Provider ID Qualifier	ID	2/2		SV
2100C	NM109	Billing Provider ID	AN	8/8	Billing Provider ID from original submitted document	
2100D		**Subscriber**				
2100D	NM101	Entity Identifier Code	ID	2/2	Patient	QC
2100D	NM108	Subscriber ID Qualifier	ID	2/2		MI
2100D	NM109	Subscriber ID	AN	9/9	Subscriber ID from original submitted document	
2200D		**Claim Service Date**				
2200D	DTP03	Date Range	AN	17/17	Range of dates covered by original document	

5.4 Record Layout 277 for Response

Following is the record layout for the ASC X12 277 transaction. Elements not listed in this table will contain the data submitted in the 276 transaction, where required.

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2100C		**Provider Name**				
2100C	NM109	Identification Code	AN	8/8	Billing Provider ID	
2100D		**Subscriber Name**				
2100D	NM101	Entity Identifier Code	ID	2/2	Patient	QC
2100D	NM108	Subscriber ID Qualifier	ID	2/2		MI
2100D	NM109	Subscriber ID	AN	9/9	Subscriber ID from original submitted document	
2200D		**Claim Service Date**				
2200D	DTP03	Date Range	AN	17/17	Range of dates covered by original document	

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2200D		**Status Information**				
2200D	STC01-1	Status Category Code	AN	2/2	Standard codes are used for claims; the following codes are used for TARS: **A4** – **Acknowledgement/Not Found** – TAR not found in adjudication system. **T1** – **Finalized/Approved** –TAR has completed adjudication process, and one or more procedures have been approved. **T2 – Finalized/Denied** – TAR has completed adjudication process, and no procedures have been approved. **T3 – Pending/In Process** – TAR is in adjudication system. **T4 – Pending/Requested Information** – TAR awaiting information already requested.	
2200D	STC01-2	Status Code	AN	1/1	The following codes are supported: **0** – Cannot provide further status electronically. **1** – For more detailed information, see remittance advice.	
2200D	STC02	Status Effective Date	DT	8/8	Date of last action taken on document.	
2200D	STC04	Total Amount Billed	R	1/18	Total of charges on claim or TAR.	

Loop	Element	Description	Format	Min/ Max	Comments / Purpose	Constant Value
2200D	STC05	Claim Payment Amount	R	1/18	Total amount paid on processed claim.	
2200D	STC06	Payment Date	DT	8/8	Same as check issue date. Only used for paid claims.	
2200D	STC07	Payment Method Code	ID	3/3	Only used for paid claims	CHK
2200D	STC08	Check Issue Date	DT	8/8	Only used for paid claims	
2200D	STC09	Check Number	AN	9/9	Only used for paid claims	

6. TESTING AND CERTIFICATION PROCESS

6.1 Overview

All submitters are required to successfully complete a testing and certification phase before they are authorized to submit production data electronically. The certification process ensures the submitter has established communications with the EDI facility and is prepared to submit documents electronically, receive reports and data from Denti-Cal, and act upon those reports when appropriate. In most cases, testing is conducted over the course of several test sessions.

All trading partners must complete four general categories of testing:

1. Data communications
2. Data formatting
3. Receipt of reports and data
4. Document correction

(Note: A correction refers to the total replacement of an EDI document in response to an RTD.)

TESTING AND CERTIFICATION OVERVIEW

All testing must be scheduled, and consists of the following four categories:

1) Data Communications Testing
2) Data Format Testing
3) Receipt of Reports and Data
4) Document Correction

For providers transmitting only first-time documents, data format testing is narrower in scope, with no requirement for document correction testing. Fictitious patient and provider names, birth dates and identifying numbers should be used for test transmissions.

Data formats for the EDI X12 transactions are explained in the X12 Implementation Guides, published by Washington Publishing Company (WPC) and available on the WPC web site.

Sections 4 and 5 of this Companion Guide contain X12 mapping, which illustrates the X12 data segments and elements for all required Denti-Cal information.

If trading partners intend to submit only first-time documents (i.e., claims and TARs), testing for data formatting is reduced in scope, and testing for document corrections is not required. If, at a later date, transmitting additional types of EDI documents is desired, additional testing will be required.

6.2 Test Scheduling

Trading partners may contact Denti-Cal EDI Support to schedule a mutually convenient time for data communications and data format testing. Denti-Cal EDI Support schedules subsequent testing upon review and successful completion of each testing phase.

6.3 Data Communications Testing

Trading partners must demonstrate four data communications functions:

- Establish a connection with the EDI facility.
- Format commands that allow files to be transmitted.
- Format commands that request reports and data to be returned to the submitter
- Disconnect from the EDI facility

6.4 Data Format Testing

Data format testing is designed to verify the submitter's ability to create files using the most currently approved version of the ASC X12 transaction set. The transactions accepted by Denti-Cal are the X12 837 and 276. See sections 4 and 5 for details on testing these transaction types.

Appendix A – EOB Data File

The EOB Data File delivers EOB information in file format rather than a report format. It is an available option for the trading partner. Appendix A illustrates the EOB Data File format and includes a data element level definition of the individual record fields.

APPENDIX A OVERVIEW

Defines EOB Data File fields and record types.

Illustrates EOB Data File record layouts.

The EOB Data File is comprised of six record types:

1. Claim Header Record
2. Claim Service Line Detail Record
3. Accounts Payable Detail Record
4. Levy Detail Record
5. Accounts Receivable Detail Record
6. Check Cycle Summary Record

Each record type is distinguished by the value in the first position of each record. All records within the file are the same length with blanks used to pad each record to a fixed length.

The Claim Header Record shows claim level EOB information on a single claim. The Claim Service Line Detail Record identifies EOB information relative to a specific service line. There is one Claim Service Line Detail Record per claim service line.

The Check Cycle Summary Record provides summary level information regarding claims payments, adjustments and non-claims transactions.

The other record types identify non-claims specific information pertaining to the provider's account, and they may or may not be present in an individual EOB Data File.

EOB Data Field Definitions by Record Type

The following section presents the definition of each field by record type. Fields are sequenced in the order they occur within the record.

Claim Header Record

1. **Record Type**: Code, value "1", indicating the record is a Claim Header Record.
2. **Adjustment Indicator**: Identifies whether or not the information is for an adjustment. A value of "Y" indicates the data is for an adjustment.
3. **Before/After Indicator**: Identifies whether, for an adjustment, the information is for the original document or the adjustment. A value of "B" (before) indicates the data is for the original document. A value of "A" (after) indicates that the data pertains to the adjustment. A blank indicates that the information is not for an adjustment.
4. **Adjustment Correction Code**: The reason for an adjustment. Refer to the Denti-Cal Provider Manual, Section 5 – EOB Readjudication Codes, for values.
5. **Document Control Number (DCN):** The number assigned to each claim by Denti-Cal.
6. **Provider Document Control Number (PDCN)**: The provider's practice management system's internal number that uniquely identifies the document sent to Denti-Cal.
7. **Patient Last Name**: The beneficiary's last name.
8. **Patient First Name**: The beneficiary's first name.
9. **Social Security Number**: The beneficiary's social security number.
10. **Date of Birth**: The beneficiary's birth date.
11. **Medi-Cal ID Number**: The beneficiary's Medi-Cal ID Number.
12. **Claim Policy Code**: Code that represents the reason for a claim level denial.
13. **Amount Billed**: The amount billed for the document.
14. **Share-of-Cost Amount**: The amount the patient paid toward a share-of-cost obligation.
15. **Other Coverage Amount**: The amount paid by another carrier.
16. **Co-payment**: The amount of co-payment collected for the claim.
17. **Medicare Paid Amount**: The amount paid by Medicare for the claim.
18. **Allowed Amount**: The total amount allowed by Denti-Cal for all services on the claim.
19. **Amount Paid**: The total amount paid on a claim by Denti-Cal after deductions.
20. **Denti-Cal Check Number**: The number of the check issued with the EOB.
21. **Direct Deposit Indicator**: Indicates whether a payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check; a value of "N" indicates the check was not a direct deposit.
22. **Provider Number**: The billing provider's Medi-Cal Identification Number.

23. **Provider Service Office Number**: The billing provider's service office number.
24. **Check Date**: The date the EOB was issued.
25. **Filler**: Trailing blanks added to a record to make its length consistent with other records.

Claim Service Line Detail Record

1. **Record Type**: Code, value "2", indicating the record is a Claim Service Line Detail Record.
2. **Adjustment Indicator**: Identifies whether or not the information is for an adjustment. A value of "Y" indicates the data is for an adjustment. A value of "N" indicates the information is not related to an adjustment.
3. **Before/After Indicator**: Identifies whether, for an adjustment, the information is for the original document or the adjustment. A value of "B" (before), indicates the data is for the original document. A value of "A" (after) indicates that the data pertains to the adjustment. A blank value indicates the information is not adjustment-related.
4. **Adjustment Correction Code**: The reason for an adjustment. Refer to the Denti-Cal Provider Manual, Section 5 - EOB Adjudication Codes, for values.
5. **Document Control Number(DCN)**: The number Medi-Cal assigns to each claim.
6. **Provider Document Control Number (PDCN)**: The provider's practice management system's internal number that uniquely identifies the document sent to Denti-Cal.
7. **Patient Last Name**: The beneficiary's last name.
8. **Patient First Name**: The beneficiary's first name.
9. **Social Security Number**: The patient's social security number.
10. **Date of Birth**: The patient's birth date.
11. **Medi-Cal ID Number**: The patient's Medi-Cal ID Number.
12. **Status**: Identifies the status of each claim line. The status codes may be found in the Denti-Cal Provider Manual, Section 5 – EOB “Claims In Process” Reason Codes.
13. **Amount Billed**: The amount billed for each claim line.
14. **Share-of-Cost Amount**: The portion of the patient's share-of-cost payment that was deducted from the claim line allowed amount.
15. **Other Coverage Amount**: The portion of the other coverage payment that was deducted from the claim line allowed amount.
16. **Medicare Paid Amount**: The portion of the Medicare paid amount that was deducted from the claim line allowed amount.
17. **Allowed Amoun**t: The amount allowed by Denti-Cal for the claim service line.
18. **Co-payment**: The portion of the co-payment that was deducted from the claim line allowed amount.
19. **Amount Paid**: The amount paid on the claim line after deductions.

20. **Denti-Cal Check Number**: The number of the check issued with the EOB.
21. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check, a value of "N" indicates the check was not a direct deposit.
22. **Provider Number**: The provider's Medi-Cal Identification Number.
23. **Provider Service Office Number**: The billing provider's service office number.
24. **Tooth Code**: The tooth number, letter arch or quadrant on which the procedure was performed.
25. **Tooth Surface**: The surface(s) affected by the procedure.
26. **Procedure Code**: The code listed on a claim line that identifies the service performed. This code may be different from the procedure code submitted on the claim or TAR because a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim may have modified the procedure code.
27. **Procedure Quantity**: The number of occurrences of the procedure.
28. **Date of Service**: The date the service was performed.
29. **Adjudication R/S Code (Replace/Substitute Indicator)**: Code indicating whether one or more procedures were replaced with a substituted code. A value of "R" indicates the procedure was replaced. A value of "S" identifies the substituted procedure. A blank value indicates no replacement or substitution occurred for this procedure.
30. **Adjudication Reason Code**: The code that explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied.
31. **Check Date**: The date the EOB was issued.
32. **Claim Policy Code**: The reason for denial.
33. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Accounts Payable Detail Record

1. **Record Type**: Code, value "3", indicating the record is an Accounts Payable Detail record.
2. **Accounts Payable Control Number**: The number assigned by Denti-Cal, which identifies the accounts payable transaction.
3. **Reason Code**: The code, which identifies the reason for the payable. A value of "1" identifies a S/URS adjustment; "2" is for a standard A/R; "3" is for an interim payment; "4" is for a recoupment penalty; "5" is for a recoupment of an overpayment.
4. **Description**: The description associated with the accounts payable reason code.
5. **Accounts Payable Amount**: The dollar amount of the individual accounts payable transaction.
6. **Check Number**: The number of the check issued with the EOB.
7. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check, a value of "N" indicates the check was not a direct deposit.
8. **Denti-Cal Provider Number**: The billing provider's Medi-Cal Identification Number.
9. **Provider Service Office Number**: The billing provider's service office number.
10. **Check Date**: The date the EOB was issued.
11. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Levy Detail Record

1. **Record Type**: Code, value "4", indicating the record is a Levy Detail record.
2. **Levy Holder Number**: The number issued by Denti-Cal to the levy holder upon receipt of a levy request.
3. **Levy Holder Name**: The name of the levy holder.
4. **Levy Holder Check Number**: The number of the check issued to the levy holder by Denti-Cal.
5. **Levy Deduction Amount**: The amount of the payment issued to the levy holder by Denti-Cal, shown as a negative amount.
6. **Denti-Cal Check Number**: The number of the check issued with the EOB.
7. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check, a value of "N" indicates the check was not a direct deposit.
8. **Provider Number**: The billing provider's Medi-Cal Identification Number.
9. **Provider Service Office Number**: The billing provider's service office number.
10. **Check Date**: The date the EOB was issued.
11. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Accounts Receivable Detail Record

1. **Record Type**: Code, value "5", indicating the record is an Accounts Receivable Detail record.
2. **Accounts Receivable Control Number**: The number assigned by Denti-Cal, which identifes the accounts receivable transaction.
3. **Effective Date**: For standard accounts receivable transactions (Reason Code "2"), the effective date of the A/R.
4. **Reason Code**: The code identifying the reason for the receivable. A value of "1" identifies a S/URS adjustment; "2" is for a standard A/R; "3" is for an interim payment; "4" is for a recoupment penalty; "5" is for a recoupment of an overpayment.
5. **Description**: The description associated with the accounts receivable reason code.
6. **Opening Balance**: The A/R amount of the provider's account at the beginning of the check write.
7. **Applied Amount**: The dollar amount of the individual accounts receivable transaction.
8. **New Balance**: The accounts receivable amount remaining after the A/R transaction has been applied.
9. **S/URS Recoupment Number**: The reference number associated with S/URS adjustment accounts receivable (Reason Code "1") transactions.
10. **Client Check Number**: The number of the check issued with the EOB.
11. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check, a value of "N" indicates the check was not a direct deposit.
12. **Provider Number**: The provider's Medi-Cal Identification Number.
13. **Provider Service Office Number**: The billing provider's service office number.
14. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

Check Cycle Summary Record

1. **Record Type**: Code, value "6", indicating the record is a Check Cycle Summary record.
2. **Total Paid Amount**: The total amount paid on other than adjustments.
3. **Total Adjusted Amount**: The net amount paid on all adjustments.
4. **Total Payable Amount**: The total amount of all accounts payable transactions.
5. **Total Levy Amount**: The total amount of all levies transactions.
6. **Total A/R Amount**: The total amount of all accounts receivable transactions.
7. **Total Co-payment**: The total co-payment collected on the claims.
8. **Total Check Amount**: The amount of the check that is for the EOB.
9. **Denti-Cal Check Number**: The number of the check issued for the EOB.

10. **Direct Deposit Indicator**: Indicates whether the payment was deposited directly into the billing provider's account. A value of "Y" identifies a direct deposit check, a value of "N" indicates the check was not a direct deposit.
11. **Provider Number**: The provider's Medi-Cal Identification Number.
12. **Provider Service Office Number**: The billing provider's service office number.
13. **Check Date**: The date the EOB was issued.
14. **Filler**: Trailing blanks added to a record to make the length consistent with other records.

EOB Record Formats

This section presents the format of each EOB record type. Fields are positional within each record and the starting and ending position of each field is defined in the tables below under "Position". The "Picture" refers to the data type and length of the data element and is expressed in COBOL terminology. Fields with a picture beginning in "X" are alphanumeric fields, those beginning with "9" and ending in ". 99" are money fields and all other fields beginning with "9" are numeric fields. For alphanumeric and numeric fields, the number within the parentheses identifies the field length. For money fields, the number within the parentheses indicates the number of dollar positions, while the "99" following the "." indicates two decimal places for the cents figure. Numeric and money fields include leading zeroes while alphanumeric fields include trailing blanks. A positive or negative sign precedes the first position of each money field.

Claim Header Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "1"
2	Adjustment Indicator	X(1)	02-02	
3	Before/After Indicator	X(1)	03-03	
4	Adjustment Correction Code	X(2)	04-05	
5	Document Control Number (DCN)	X(11)	06-16	
6	Provider Document Control Number (PDCN)	X(17)	17-33	
7	Patient Last Name	X(12)	34-45	
8	Patient First Name	X(10)	46-55	
9	Social Security Number	X(9)	56-64	
10	Date of Birth	X(6)	65-70	MMDDYY
11	Medi-Cal ID Number	X(14)	71-84	
12	Policy Code	X(2)	85-86	
13	Amount Billed	-9(5).99	87-95	
14	Share-of-Cost Amount	-9(4).99	96-103	
15	Other Coverage Amount	-9(5).99	104-112	
16	Co-payment	-9(3).99	113-119	
17	Medicare Paid Amount	-9(5).99	120-128	
18	Allowed Amount	-9(5).99	129-137	
19	Paid Amount	-9(5).99	138-146	
20	Denti-Cal Check Number	9(9)	147-155	
21	Direct Deposit Indicator	X(1)	156-156	
22	Provider Number	X(6)	157-162	
23	Provider Service Office	9(2)	163-164	
24	Check Date	X(6)	165-170	MMDDYY
25	Filler	X(30)	171-200	

Claim Service Line Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "2"
2	Adjustment Indicator	X(1)	02-02	
3	Before/After Indicator	X(1)	03-03	
4	Adjustment Correction Code	X(2)	04-05	
5	Document Control Number (DCN	X(11)	06-16	
6	Provider Document Control Number (PDCN)	X(17)	17-33	
7	Patient Last Name	X(12)	34-45	
8	Patient First Name	X(10)	46-55	
9	Patient Social Security Number	X(9)	56-64	
10	Patient Date of Birth	X(6)	65-70	MMDDYY
11	Patient Medi-Cal ID Number	X(14)	71-84	
12	Status	X(1)	85-85	
13	Amount Billed	-9(5).99	86-94	
14	Share of Cost Amount	-9(4).99	95-102	
15	Other Coverage Amount	-9(5).99	103-111	
16	Medicare Paid Amount	-9(5).99	112-120	
17	Allowed Amount	-9(5).99	121-129	
18	Co-payment	-9(3).99	130-136	
19	Paid Amount	-9(5).99	137-145	
20	Denti-Cal Check Number	9(9)	146-154	
21	Direct Deposit Indicator	X(1)	155-155	
22	Provider Number	X(6)	156-161	
23	Provider Service Office	9(2)	162-163	
24	Tooth Code	X(2)	163-165	
25	Tooth Surface	X(5)	166-170	
26	Procedure Code	X(5)	171-175	
27	Procedure Quantity	9(2)	176-177	
28	Date of Service	X(6)	178-183	
29	Adjudication R/S Code	X(1)	184-184	
30	Reason Code	X(4)	185-188	
31	Check Date	X(6)	189-194	MMDDYY
32	Claim Policy Code	X(2)	195-196	
33	Filler	X(04)	197-200	

Accounts Payable Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "3"
2	Accounts Payable Control Number	X(7)	02-08	
3	Reason Code	X(1)	09-09	
4	Description	X(40)	10-49	
5	Accounts Payable Amount	-9(7).99	50-60	
6	Denti-Cal Check Number	9(9)	61-69	
7	Direct Deposit Indicator	X(1)	70-70	
8	Provider Number	X(6)	71-76	
9	Provider Service Office	9(2)	77-78	
10	Check Date	X(6)	79-84	MMDDYY
11	Filler	X(116)	85-200	

Levy Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "4"
2	Levy Holder Number	X(9)	02-10	
3	Levy Holder Name	X(40)	11-50	
4	Levy Holder Check Number	9(9)	51-59	
5	Levy Deduction Amount	-9(6).99	60-69	
6	Denti-Cal Check Number	9(9)	70-78	
7	Direct Deposit Indicator	X(1)	79-79	
8	Provider Number	X(6)	80-85	
9	Provider Service Office	9(2)	86-87	
10	Check Date	X(6)	88-93	
11	Filler	X(107)	94-200	

Accounts Receivable Detail Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "5"
2	Accounts Receivable Control Number	X(5)	02-06	
3	Effective Date	X(6)	07-12	MMDDYY
4	Reason Code	X(1)	13-13	
5	Description	X(40)	14-53	
6	Opening Balance	-9(7).99	54-64	
7	Applied Amount	-9(7).99	65-75	
8	New Balance	-9(7).99	76-86	
9	S/URS Recoupment Number	X(3)	87-89	
10	Client Check Number	9(10)	90-99	
11	Direct Deposit Indicator	X(1)	100-100	
12	Provider Number	X(6)	101-106	
13	Provider Service Office Number	9(2)	107-108	
14	Filler	X(92)	109-200	

Check Cycle Summary Record

Fld#	Data Element	Picture	Position	Comments
1	Record Type	X(1)	01-01	Constant "6"
2	Total Paid Amount	-9(6).99	02-11	
3	Total Adjusted Amount	-9(6).99	12-21	
4	Total Payable Amount	-9(7).99	22-32	
5	Total Levy Amount	-9(6).99	33-42	
6	Total A/R Amount	-9(7).99	43-53	
7	Total Co-payment Amount	-9(6).99	54-63	
8	Total Check Amount	-9(7).99	64-74	
9	Denti-Cal Check Number	9(9)	75-83	
10	Direct Deposit Indicator	X(1)	84-84	
11	Provider Number	X(6)	85-90	
12	Provider Service Office	9(2)	91-92	
13	Check Date	X(6)	93-98	MMDDYY
14	Filler	X(102)	99-200	

– End of Section –

Appendix B – Report Examples

This appendix provides examples of reports available to providers by electronic retrieval. Example layouts of each report discussed in Section 3.2, Reports Available, are presented with a brief description of each report.

APPENDIX B OVERVIEW

Example layouts of reports available for electronic retrieval.

Brief descriptions of each report.

CP-O-959-P Provider/Service Office Document Rejections

EDI submitters use this report to identify rejected EDI transactions and determine whether correction and resubmission are required.

REPORT ID: CP-O-959-P DENTI-CAL RUN ON: MM/DD/YY
PERIOD ENDING: 11/19/03 PROVIDER/SVC OFC PAGE: 1
PROGRAM ID: DCB969BS ... DOCUMENT REJECTIONS .....

PROV/SVC NUMBER	PROVIDER DCN	RECIPIENT LAST	NAME FIRST	D T	SSN / CIN OR MEDS	BASE DCN	RSN CD
ANNNNN-NN	9999999999	LAST1	FIRST1	X	999999999		A
AXXXXX-XX	XXXXXXXXXX	LAST2	FIRST2	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST3	FIRST3	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST4	FIRST4	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST5	FIRST5	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST6	FIRST6	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST7	FIRST7	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST8	FIRST8	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST9	FIRST9	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST10	FIRST10	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST11	FIRST11	X	XXXXXXXXX		A
AXXXXX-XX	XXXXXXXXXX	LAST12	FIRST12	X	XXXXXXXXX		A

PROVIDER/SERVICE OFC TOTALS

A - INVALID PROV/SVC OFC	:	ZZ,ZZ9
B - INVALID C/H	:	ZZ,ZZ9
C - INVALID PROV/CH	:	ZZ,ZZ9
D - BATCH REJECTED	:	ZZ,ZZ9
E - RECORD COUNTS MISMATCH	:	ZZ,ZZ9
F - INVALID PROVIDER NAME	:	ZZ,ZZ9
G - DUPLICATE DOCUMENTS	:	ZZ,ZZ9
H - SECOND NOA ISSUED	:	ZZ,ZZ9
I - INVALID RETURN DCN	:	ZZ,ZZ9
J - SUB/PROV/SITE MISMATCH	:	ZZ,ZZ9
K - CLAIM OVER 40 LINES	:	ZZ,ZZ9
TOTAL REJECTIONS	:	ZZZ,ZZ9

CP-O-971-P Provider Service Office X-Ray/Attachment Request

This report is transmitted to submitters to identify the TARs and claims submitted electronically that require X-rays and/or attachments. By providing both the Denti-Cal Key DCN and the internal control number assigned by the provider (PDCN) to each document, the report enables providers to easily identify the TARs and claims associated with x-rays and/or attachments sent through the mail.

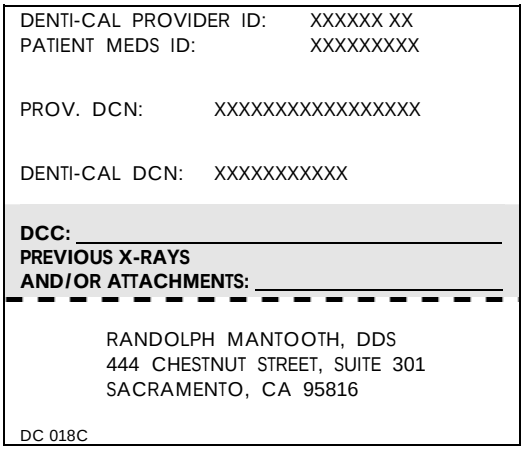
```
REPORT ID:      CP-O-971-P              DENTI-CAL                    RUN ON:     MM/DD/YY
PERIOD ENDING:  11/19/03            PROVIDER/SVC OFC                 PAGE:          1
PROGRAM ID:     DCB971BS        X-RAY/ATTACHMENT REQUEST

PROV/SVC        BASE        PROV                RECIPIENT       NAME            SSN/CIN/
NUMBER          DCN         DCN                 LAST            FIRST           OR MEDS
XNNNNN-NN       YYDDDTSSSSS XXXXXXXXXXXX        LAST1           FIRST1
MEDI CAL NBR:   XXXXXXXXXXX       SYS IND: ***  DOC TYPE: x     SUBMIT AMOUNT:     ZZZ,ZZ9
XNNNNN-NN       YYDDDTSSSSS XXXXXXXXXXXX        LAST2           FIRST2
MEDI CAL NBR:   XXXXXXXXXXX       SYS IND: ***  DOC TYPE: x     SUBMIT AMOUNT:     ZZZ,ZZ9

** TOTAL X-RAY/ATTACHMENT REQUESTS FOR PROV/SVC OFC.:        ZZZ,ZZ9
```

CP-O-971-P2 Provider X-Ray/Attachment Labels

These labels are transmitted to submitters for use in identifying the TARS, claims and RTDs associated with X-rays and attachments sent to Denti-Cal through the mail. Providers receiving the labels affix them to x-ray envelopes or Attachment Header Sheets before mailing. Each label includes a perforated section on which the provider's name and address are printed. This section of the label is used for mailing X-rays back to providers. Special adhesive used on the labels enables them to be removed easily before the return mailing to the provider.



CP-O-973-P Provider/Service Office Daily EDI Documents Received Today

This report, which lists all EDI documents received from a provider service office on the report date, is sent to providers to serve as a cross-reference between Denti-Cal's DCN and the PDCN. The report is a confirmation of claims, TARs and RTDs received.

```
REPORT ID:      CP-O-973-P                DENTI-CAL                RUN ON:    MM/DD/YY
PERIOD ENDING:  11/19/03                PROVIDER/SVC OFC           PAGE:          1
PROGRAM ID:     DCB973BS      DAILY EDI DOCUMENTS RECEIVED TODAY

PROV     SV     PROVIDER       BASE          RECIPIENT     NAME          SSN/CIN/
NUMBER   OF     DCN            DCN           LAST          FIRST         OR MEDS
XNNNNN-NN       YYDDDTSSSSS    XXXXXXXXXXX   LAST1         FIRST1
MEDI CAL NBR:   XXXXXXXXXXX      DOC TYPE:   x       SUBMITTED FEE:     ZZZ,ZZ9
XNNNNN-NN       YYDDDTSSSSS    XXXXXXXXXXX   LAST2         FIRST2
MEDI CAL NBR:   XXXXXXXXXXX      DOC TYPE:   x       SUBMITTED FEE:     ZZZ,ZZ9

TOTAL PROV/SVC OFC DOCUMENTS:                ZZ,ZZ9
```

CP-O-978-P Provider/Service Office Daily EDI Documents Waiting Return Information > 7 Days

This report, which lists all EDI documents that have been awaiting X-rays and/or attachments for more than seven days, is sent to providers as a follow-up to the original request. Providers who opt to receive this report can identify documents on which the X-ray or attachment indicator was turned on erroneously.

```
REPORT ID:       CP-O-978-P                  DENTI-CAL                        RUN ON:    MM/DD/YY
PERIOD ENDING:   01/17/01                    PROVIDER/SVC OFC                 PAGE:           1
PROGRAM ID:      DCB978BS    DAILY EDI DOCUMENTS WAITING RETURN INFORMATION > 7 DAYS

PROV     SV  ISSUE      DAYS  SSN/CIN/     MEDI-CAL      RECIPIENT     NAME       TYPE OF
NUMBER   OF  DATE       SNCE  OR MEDS      NUMBER        LAST          FIRST      REQUEST
XNNNNN-NN    MM/DD/YY    99   NNNNNNNNN    XXXXXXXXXXX   LAST1         FIRST1     XRAY/ATTCH
PROV DCN:    XXXXXXXXX         BASE DCN:    YYDDDTSSSSS   DOC TYPE: x   SUB AMT:       ZZZ,ZZ9
XNNNNN-NN    MM/DD/YY    99   NNNNNNNNN    XXXXXXXXXXX   LAST2         LAST2      XRAY/ATTCH
PROV DCN:    XXXXXXXXX         BASE DCN:    YYDDDTSSSSS   DOC TYPE: x   SUB AMT:       ZZZ,ZZ9

TOTAL PROV/SVC OFC DOCUMENTS:                ZZ,ZZ9
```

CP-O-RTD-P Notice of Resubmission (Electronic RTD)

Trading partners may select to receive this electronic report in lieu of hard copy RTDs. Electronic RTDs consist of report records that may be printed by a clearinghouse, billing intermediary or provider office. Once printed, the electronic RTDs may be completed like the current hard copy RTD form, signed and returned to Denti-Cal for processing.

(CP-O-RTD-P) NOTICE OF RESUBMISSION MM/DD/YY HH:MM:SS PAGE NN OF NN
BUSINESS NAME AND ADDRESS RTD ISSUE DATE: MM/DD/YY
SERVICE OFFICE/ FICTITIOUS NAME XNNNNN-NN RTD DUE DATE: MM/DD/YY
LAST, FIRST, DDS

XXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX XX 99999-9999

DOCUMENT TYPE : CLAIM
BEGINNING DOS : MM/DD/YY
PROVIDER DCN : TEST000002

---------- PATIENT INFORMATION ----------

LAST NAME	FIRST NAME	MEDICAL ID NBR	DENTAL REC	AMOUNT BILLED	DCN
XXXXXXXXXXX	XXXXXXX	XXXXXXXXXXXXXX		99999.99	YYDDDTSSSSS

INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE
BENE EOB DATE	99	99	MM–DD–YY	99999

ERROR CD: 99 DESC: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CORRECT INFORMATION: _____

X_____ _____
SIGNATURE DATE

NOTE: PLEASE CORRECT THE CLAIM/TAR/NOA. RESUBMIT A COPY OF THIS FORM THRU THE MAIL OR IF YOUR SYSTEM IS ABLE TO RESPOND TO RTDS ELECTRONICALLY, RETRANSMIT THE ENTIRE DOCUMENT. MAIL ANY REQUIRED X-RAYS/ATTACHMENTS IN THE APPROPRIATE COLORED ENVELOPE, WRITING IN THE DOCUMENT CONTROL NUMBER (DCN). PLEASE INCLUDE THE DENTI-CAL ASSIGNED DCN ON ANY OTHER COMMUNICATIONS WITH DENTI-CAL.

CP-O-NOA-P Notice of Authorization

Trading partners may select to receive this electronic report in lieu of hard copy NOA forms. Electronic NOAs consist of report records that may be printed by a clearing house, billing intermediary or provider office. Once printed, they may be completed like the current hard copy NOA, signed and returned to Denti-Cal for billing.

(CP-O-NOA-P) NOTICE OF AUTHORIZATION MM/DD/YY HH:MM:SS PAGE NN OF NN
DCN: YYDDDTSSSSS X AUTHORIZATION PERIOD FROM MM/DD/YY TO MM/DD/YY

RE-EVALUATION IS REQUESTED __ (X FOR YES)

PATIENT NAME (LAST, FIRST,MI)	SOC SEC NO	SEX	BIRTHDATE	MEDI-CAL ID NO
XXXXXXXXXXX XXXXXX X	999-99-9999	X	MM/DD/YY	99999999999999

PATIENT DENTAL RECORD NO. :
PROVIDER DOC CONTROL NUMBER : XXXXXXXXXX

X-RAYS ATTACHED __ (X FOR YES) HOW MANY? ____ ACCIDENT/INJURY __ (X FOR YES)
OTHER ATTACHMENTS __ (X FOR YES) EMPLOYMENT RELATED __ (X FOR YES)
OTHER DENTAL COVERAGE __ (X FOR YES) CHDP __ (X FOR YES)

BUSINESS NAME AND ADDRESS
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX XX 99999-9999

BIC ISSUE DATE: _____

EVC #: _____

TO SURF	LN	DESCRIPTION-OF-SVC	DATE-PER	QTY	PROC	FEE	ALLOW	ADJ-C	PROVID
	01	SUBGING CURETTAGE	XX/XX/XX	01	452	50.00	0.00	074B	_____

DATE PROSTHESIS ORDERED : _____
PROSTHESIS LINE ITEM : __ __ __ __

TOTAL FEE CHARGED 50.00
TOTAL ALLOWANCE 0.00
PATIENT SHARE-OF-COST AMT. _____
OTHER COVERAGE AMT. _____
DATE BILLED _____

COMMENTS:

X_____ _____
SIGNATURE DATE

NOTE: PLEASE REFER TO THIS NBR (YYDDDTSSSSS) ON ALL YOUR COMMUNICATIONS WITH DENTI-CAL, INCLUDING ELECTRONIC TRANSACTIONS CONCERNING THIS DOCUMENT.